

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community 8 years
years, months or days)

3. (a) PRINT FULL NAME Larry Williams

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female / 5. Color or race Negro
6. (a) Single, widowed, married, divorced Sep.

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 33 hr. min.

9. Birthplace Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Arron Young

12. Name Arron Young
13. Birthplace Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Annie Hopkins
15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith
(b) Address 2601 N. Whittier

17. (a) Burial, cremation, or removal
(b) Date of death April 28, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar)
(b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 2011 Rear Carr
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28,
year 1943 hour 1 minute 40 A. M.

21. I hereby certify that I attended the deceased from April 18, 1943 to April 28, 1943.

that I last saw him alive on April 28, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death
Meningitis, (cause unknown)
Duration 1 week

Due to
Due to
Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(e) Means of injury

23. Signature (M. D. or other)
Address Date signed

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.